The Catholic Hospital Association of India

Hospitals and Other Health Care Institutions

HEALTH POLICY GUIDELINES

(Draft)

HEALTH POLICY GUIDELINES

i. GENESIS OF THE POLICY GUIDELINES

The Catholic Hospitals have been rendering outstanding services towards the health of our people. That the hospitals have been meeting the needs of our people and that the services are appreciated are shown by the large increase in the number and variety of health care institutions under Catholic auspices. Today , there are about 2,500 health care institutions (hospitals, health centres and dispensaries) affiliated to the Catholic Hospital Association of India.

The Catholic hospitals and other health care institutions have been discharging their duties and responsiblities, each in its own way, or at best, according to the policies of the particular congregation or diocese. With the newer concepts in health care, there has been a re-thinking of the role of our hospitals. It is time to take stock of what we are doing and where we are going, so that we can be of even greater service. The Catholic Hospital Association of India therefore considered it appropriate to bring out the policy guidelines for the affiliated institutions.

Dr. C.M. Francis had been involved for sometime now in evolving some guidelines for hospitals. The Catholic Hospital Association of India requested him to work on the guidelines suitable for our hospitals. He produced a draft of the health policy guidelines and suggested that a committee be constituted to consider and improve the draft. Accoringly, a committee was constituted. The committee has considered the draft in detail and the present draft is the result.

The Chapter on the Use of drugs and phramaceut icals gives the policy of Rational Drug Use. A formulary is under preparation under the joint auspices of the Catholic Hospital Association and the Christian Medical Association of India.

It is proposed that this draft policy guidelines be considered by each member institution and also discussed in regional and other groups so as to evolve acceptable health policy guidelines for our member institutions. Certain changes will be effected in the light of the deliberations of the Convention in November 1988 and on the basis of suggesitions from the member institutions. The final draft will then be placed before the CHAI Convention in 1989.

ii. HEALTH POLICY GUIDELINES COMMITTEE

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POLICY GUIDELINES FOR THE HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS AFFILIATED TO THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

I. INTRODUCTION

The Hospitals and other Health Care Institutions, who are members of the Catholic Hospital Association of India (CHAI) have been rendering service to the people of our country. That such service meets a felt need and is appreciated by the people shown by the phenomenal growth in numbers and activities of these institutions. At the time of our country gaining independence, there were about 400 Catholic health care institutions in the country. There are, at present, about 2500 such institutions, most of them being small hospitals, health centres and dispensaries spread throughout the length and breadth of the country. More than 2000 of them are situated in the rural areas. These institutions, large and small, have been making enoromous efforts in the care of the sick and suffering, in the promotion of health and in the prevention of iliness. These efforts are likely to bear even better fruits in the improvement of the health of the people, if a sense of direction is given in the light of the New Vision of Health and Healing. Each institution will continue to enjoy its autonomy and promote the specific areas fo thrust in health and development. The rich variety of efforts add on to the mosaic of health care in the country. The successful innovative programmes become models for adoption and adaptation by others in the field. These policy guidelines are meant to help the institutions to be more relevant to the needs of the people and to be more creative in providing comprehensive health care. A better co-ordination can also be expected.

2. India's Health Policy

Institutions affiliated to CHAI must be aware of India's Health Policy and co-operate with the Government in its efforts to improve the health of the people. Our institutions can also be pace-setters giving new directions to the country's health policy. It may not always be possible to follow the Government policy, especially in areas where it may conflict with the Catholic view point. In such instance, it may be necessary to refrain from the non-acceptable directions of the Government and try to modify the policy.

The policy of the institutions affiliated to CHAI can be effective, if it falls in line with India's Health Policy, complementing and supplementing it and adding to it, as necessary.

2.1. The ancients in India had the idea of health and freedom from disease for all, "Sarve Santu Niraamay" (Let all be without disease). India has a rich heritage of health sciences with a holistic approach. It took into account all aspects of health and disease. There were clear instructions of *dinacharyas* (daily routine) how to promote health and prevent disease and what to do in case of sickness. But this system fell into disrepute in later years. The health status of the vast majority of the people has deteriorated, producing a dismal picture. The vicious cycle of poverty, unemployment, malnutrition and illiteracy has made the situation intolerable. Almost all the health indices cry out for immediate change. Infant mortality is over 100 per thousand. The mortality rates for women and children are distressingly high. While the life expectation at birth has doubled from 27 years to almost 55 years since Independence, it is still more than 20 years below the affluent countries The extent of malnutrition continues to be widespread. Communicable diseases continue to ravage all parts of the country, While these diseases of underdevelopment are with us, some of the diseases more characteristic of the more affluent countries, like cancer, are also on the increase. Contrast with the declarations on Human Rights: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family ...." U.N. Universal Declaration of Human Rights, and "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition", the preamble to the W.H.O. constitution.

2.2. Health is dealt with in the *Directive Principles of State Policy* in the Indian constitution. India's Health Policy has stemmed largely from the report (1946) of the "Health Survey and Development" Committee under the Chairmanship of Sir Joseph Bhore. It gave comprehensive proposals, both long-term and short-term, for the development of health care services in the country. While the proposals were good, implementation was poor. Later, many committees were constituted to review and suggest ways and means of improving the health of the people. The most significant among the later events as regards policy was the passing of the "National Health Policy" by the Parliament. (1982). The Statement on the Indian National Health Policy, Government of India, declares "The Constitution of India ..... aims at the elimination of poverty, ignorance and ill health and directs the state to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of the workers, men and women, specially ensuring that children are given opportunities and facilities to development in healthy manner".

3. Voluntary efforts

3.1. The Government has recognised the importance of the non-governmental contributions in health care. The National Health Policy (1982) recognises the importance of the voluntary agencies in the field of health and development and states that their "services and support would require to be utilised and intermeshed with the governmental efforts in an integrated manner". One of the major strengths of the non-governmental agencies is the ability for new orientation and innovation and which may be adopted later by the Government. They are also able to better reach out to the unreached people.

3.2. Most of our older institutions started health care motivated by charity but later the component of development has been added on, making newer ones health and development oriented. A few are also taking up increasingly the role of mobilising the people of the area to assert their right to health care. Through formal and informal methods, information is made available to the people to become agents for change.

3.3. The voluntary efforts are significant. In 1982, 43.8% of the hospitals in the country were owned and managed by the voluntary agencies. The proportion of hospital beds was 27.6% which would mean that per institution, the number of beds is smaller, showing a wide distribution in the country.

3.4. The amount budgetted for health care by the Government is small both in relation to the Gross National Product and per capita expenditure. During the successive Five-Year Plans the proportion allotted to Health care services has been reduced. There is need to enhance this allotment. L.K. Jha, Chairman, Economic Administration Reforms Commission, Government of India, 1984, stated: "Firstly, it can be argued, and I would agree with it fully, that more resources should be provided and priority should be given to health care. More deserves to be spent on the health of the people not only because human life is precious and should be preserved and prolonged, but also because, even from a narrow, materialistic or economic point of view, with better health the population will be much more productive.

"Thus, higher outlays on health should be viewed as not just acts of generosity but also as good investment. But as a realist, I would also have to recognise that there are so many other pressing claims on the nation's resources that with the best will in the world, the paucity in the health sector will exist". It is necessary that the voluntary sector should supplement, quantitatively and qualitatively, the work of the Government.

4. The major thrusts of our health policy would be :

(1) Re-orient our health care institutions to increasingly participate in *promotion of health, prevention of disease* and *rehabilitation* of the disabled, in addition to improving curative care.

(2) Have a holistic approach - environmental, social, physical, psychological and spiritual, providing compassionate and loving care. open to all methods and systems of health care.

(3) Integrate with the health care services provided by the Government (central, state and local bodies) and Non-Governmental organisations to provide health care where most needed and participate actively in the National Health Programme, such as control of tuberculosis,

(4) Provide competent and adequate health care to the individual in the context of the family and the community, helping them to carry out their responsibilities to build healthy families and communities.

(5) Participate in and give support to Primary Health care.

(6) Utilise modern science and technology to the extent they improve the health of the people, being aware of the resources and the economic and social implications.

(7) Bring about Rational Drug Use, using quality and cost-effective medicines, irrespective of the system and include traditional and home remedies.

(8) Be good stewards of the resources available, being examples of integrity and social justice.

(9) Wherever possible, train appropriate health manpower and utilise their services effectively.

(10) Do all the above according to Christian values and principles.

5. Why should we serve?

We are called upon to participate in the Healing Ministry because of the direct mandate from Christ, the Great Physician: "Heal the sick, raise the dead, cleanse lepers and cast out demons" - (Mathew, 10:3); "Go and tell John what you hear and see: the blind receive their sight and the lame walk, lepers are cleansed and the deaf hear and the

dead are raised up and the poor have good news preached to them" (Mathew 11:4, 5).

"He (Christ) went about healing every disease and every infirmity" (Mathew 4:23).

We have any number of examples of the Acts of Healing by Christ restoring people to wholeness, physically and spiritually. It is our duty as His followers to emulate his example and continue His Healing Ministry. Responding to the call, the church has provided health care services, though this has been inadequate compared to the needs.

Jesus cured people, who needed his care, without any other consideration. "A leper now came up and bowed low in front of him 'Sir, he said, if you want to you can cure me'. Jesus stretched out his hand, touched him and said 'Of course I want to! Be cured!" (Mathew 8:2).

The Christian health care endeavour finds the model in Jesus, who came so that people may have life and that abundantly. Jesus' ministry consisted of preaching and healing. His followers are expected to continue this mission. Indeed the early Christians followed the commission by Jesus to proclaim the good news by preaching and healing. The healing of Physical illness was seen as evidence of the work of the Holy Spirit. The Church as the Body of Christ and as the Community through which the Holy Spirit operates is charged with the commission to heal the sick. "Is any among you sick? Let him call for the elders of the Church and let them pray over him, anointing him with oil in the name of the Lord".

Christians consider the human being as a marvellous work of Divine Creation, to be the very image of God. The human person is a body living with spiritual life open to share in the eternal life of God. Even when sickness cannot be overcome, the struggle against it can be an experience which helps in the moral and spiritual growth. The Christian health workers co-operate with God, helping the suffering human being to live a fuller life. Sickness is an opportunity given by God to proclaim His wonderful works and give Him glory (Morris Madiocks 1981).

6. Whom should we serve?

6.1. Jesus healed all who sought his help. We also should do the same. Discrimination between the rich and the poor is described as a blasphemy against God who shows no partiality. The Asian Bishops' Conference (BISA IV) said: "We agree with the bishops of Latin America

that our preferential option should be for the poor". Very often, the people who need our help are unable to get it because of problems of accessibility. We have to go out of our way, as Jesus did.

6.2. When the resources are limited, we have to make options and Jesus has told us how to make the choice: "Whenever you have done it to the least, you have done it to me". In order to make our contribution genuinely Christian, greater attention must be paid to the poor sick. This is also in consonance with the Indian thinking. Gandhiji said: "I will give you a talisman. Whenever you are in doubt or when the self becomes too much with you, apply the following test. Recall the face of the poorest and weakest man you have seen and ask yourself, if the step you contemplated is going to be of any use to him. Will he gain anything by it". We should aim at a certain basic minimum of health care becoming available to all in the shortest time possible. After that, we can provide for those who need more expensive care, *provided the resources permit*". All agree tha tin church related medical work, priority should be given to the poor and to those who are in special need"- The Church in India Today (1969).

6.3. In His conversation with the Samaritan woman, Jesus takes the initiative to break the ethnic and racial barriers, erected by Society. The woman looks at the request of Jesus for a drink of water from the angles of race and tradition. Jesus was committed to the healing of the brokeness of everyone. No Christian health care institution or personnel can discriminate on the basis of caste, creed or such other: consideration, in providing health care. Nostra Aetati (Vatican II) states "All men form one community".

II. SOME BASIC CONCEPTS OF HEALTH

7.1. Health is a human right. It is the responsibility of every individual, family and community to attain and maintain health in all respects. Galen (2nd Century AD) says: "But since both in importance and in time, health precedes disease, so we ought to consider first how health may be preserved and then how one may best cure disease". It is also in the best tradition of Ayurveda where by attention to the *dinacharayas*, we try to maintain health and ward off illness. It is difficult to mend a broken egg (diseased heart, lung, kidney, etc); we should prevent it from breaking. There is need to promote *wellness*.

7.2. The well-being of a person, family and the community is the result of many interacting factors. The major advances in improving health and preventing diseases are derived from changing the environ-

ment and life-styles. The health personnel can play important roles in bringing about changing life styles, promoting health.

7.3. Tobacco, in different forms, can lead to a large number of diseases. Pan chewing is common in our country. Direct tobacco chewing is prevalent in many parts of the country. It can lead to oral cancer and other disabling conditions.

Smoking can cause cancer of the lung, coronary heart disease, chronic bronchitis and many other ailments. Studies in India have shown that the risk of lung cancer for cigarette smokers is 8 times more, than non-smokers. Many countries, both developed and developing have adopted legislation and taken measures to reduce smoking and to nullify the effects of aggressive advertising by the cigarette companies. The member institutions can mount effective campaign to reduce smoking.

Tobacco cultivation is a direct competitor for fertile land, which would otherwise have been used for growing food. Hence, it affects food production and nutrition.

7.4. Similar are the problems created by alcoholism. Apart from diseases, alcoholism produces social problems. India is poor. Poverty is aggravated by spending alcohol, diminished work capacity and even less of employment.

7.5. The problem of drug abuse and addiction is becoming menacing, especially among the youth. While other problems develop over a long period of time, drug addiction causes deterioration within a short period.

8. Nutrition

8.1. Nutrition has an important influence on the health status. It affects the physical growth and psychological development of children. Birth weight can be an important indicator of community nutrition.

8.2. Undernutrition affects many millions of people in our country. It reduces the energy and motivation. It undermines the performance at school. The work turnover whether in the factory or in the fields, is reduced. The resistance to disease is impaired, making the undernourished easy victims of various diseases.

8.3. The rampant malnutrition, especially present in women and children, must be reduced and finally eradicated. There is need for better food distribution (including improvement in the purchasing capacity of the people). The available food must be used better and in the proper proportions by nutrition education.

9. Quality of life

9.1. All of us are concerned with the quality of life. Assessments merely in terms of mortality and morbidity are insufficient; it is necessary to add new dimensions in terms of function and satisfaction. Physical quality of life index (PQLI) is often used to measure as the end results of development; to it must be added factors such as satisfaction and happiness.

9.2. Quality of life can be improved in almost everyone, including those who are chronically ill, handicapped, debilitated and totally helpless by loving care in the home or in rehabilitation centres.

10. Meaning of suffering

Removing or reducing suffering and pain improving health and quality of life of the people is certainly an obligation; it is an expression of our love to our neighbour and obedience to His command. Because suffering mostly is an obstacle to the fullness of life, we have a duty to try to overcome or mitigate it. But we need not be downcast, when we are not successful. Suffering and removal of suffering both seem to be a part of the working of God's purpose. C.S. Lewis said: "God whispers to us in pleasures, speaks to us in our conscious, but shouts in our pains'. John Paul II says in Salvifici Doloris: "At one and the same time, Christ has taught man to do good by his suffering and to do good to those who suffer."

11. The Christian aproach to health

11.1. A striking example Christ has placed before us is that of the Good Samaritan, sacrificing time and comforts and providing relief and sustance, "We ought to project through our medical institutions, the image of the Church as a communion of love and unity, as an institution of service of mankind, irrespective of race or creed" and "As the endeavour of the Church is to render service in the spirit of Christ, it should be our intention to provide for the health needs in places where the urgency is most acute. We should use our personnel and resources in such a way as to render the greatest possible service for the maximum number of people" - Church in India Today, 1969.

11.2. Christ is present whenever we do things in His name. This is more so when we do it to the "least" of our brothers and sisters. When we provide care for the poor and unreached, whether it be curative or preventive, it assumes a special meaning.

12. Co-operation

12.1. In our endeavours to provide health care, it is necessary to ensure that we do not unnecessarily duplicate the services. It is not

according to our Christian ideals to compete with other organisations or institutions. We should provide the necessary facilities in places which are devoid of the health care services. Where there are several hospitals (Catholic and others) existing in an area, efforts must be made to see that such hospital complements the others in the area, with primary and specialised care, Health care services provide an easy and beautiful way of practising ecumenism, Christian and wider.

12.2. There is need for a nationwide geographical area planning. Religious congregations and others, experienced in providing health care services should locate facilities in areas lacking even primary health care. The urgent need of health care facilities should be the criterion for locating newer hospitals and health centres.

12.3. The first requisite for such planning should be a nationwide survey of Catholic health care facilities - (1) hospitals, health centres and dispensaries; (2) number of doctors, nurses and paramedicals, number in training and projected output; (3) the needs. This can be followed by survey of other Christian endeavours, with a view of fellowship, co-operation and sharing of experiences and even personnel and facilities. This can then be followed by survey of other voluntary health and Governmental facilities so that together we can decide where the needs are greatest.

12.4. Catholic Health care system should supplement the efforts of the Government and other organisations. Our contribution as church - related voluntary organisations should be to make up the deficiencies and also to provide for the ethical values and spiritual well-being, which is often missing in the services provided by the civil authorities. We should do all we can to encourage the Government to provide for the health needs of the people of the area and of the country. The CHAI institutions should see that their health care programmes are integrated with the national health planning, to the extent possible.

13. Resource allocation

The resources are limited and the demands are enormous. It is necessary to deploy our resources for optimum benefit. James C.Mc Gilvray (1981) says: "The most important dimension in the field of health care today is the element of planning. Such planning seeks to define overall objectives and to identify the resources which are or may be avilable to meet them. It is now incumbent upon the churches to engage in such planning themselves if they would exercise stewardship with their resources".

14. Justice; socio-economic problems; poverty

14.1. The majority of the people are trapped in the vicious cycle of poverty, illiteracy, unemployment, malnutrition and diseases. Ill-health is often a product of an unjust society, which results in poverty and inequitable distribution of resources and opportunities. Non-affordability and non-accessibility as also social, cultural and other factors may deny equal access to health care services. An attack on ill-health should be a part of a process of developmental and social change, which seeks solutions for the issues of social injustice. The people and the communities must be enabled to get the necessary opportunities and resources that would help in the attainment and maintenance of health. The inequitable distribution of health care services can lead to greater disparities. Many of the crucial contemporary question in health policy are of distributive nature.

14.2. The social and economic status of the people is also important. Even if health facilities are available close at hand, they may not be availed of by the socially deprived. The removal of social and economic disparities preventing access to health care services is important. While removal of social injustice is important to achieve a high degree of health, we cannot wait till that is accomplished.

15. Health Education

Health education is the most important component of primary-health care and can be achieved more easily if the people are literate. Education should be a part of all programmes; it has the task of helping the people learn better the behavioural patterns and skills, enabling them to fulfill more effectively the requirements for health. The success of an educational programme can be guaged by the changes which take place in the home and the community. The Catholic Health Care Institutions can play an effective role, as they can make use of the educational institutions with which they are often closely related. A combined team approach is necessary.

16. Interdependence of various sectors

Health and development are interdependent. Health and socio-economic problems are intimately intertwined. Our efforts, to be effective, must encompass all sectors simultaneously - health, education, socio-economic aspects, agriculture, animal husbandry, employment, and eradication of poverty.

17. Secondary and tertiary care

Supporting primary health care, we need centres for secondary and tertiary care. Primary health care cannot be sustained by itself.

There is need for referrals of patients who cannot be managed at the primary care level and need specialised care. Our hospitals have been providing good specialist care. Dealing with primary health care, the statement on Indian National Health Policy, Government of India, 1982 says: "The success of the decentralised primary health care would depend initially on the organised building up of individual self-reliance and effective community participation; on the provision of organised back-up support of secondary and tertiary levels of the health care services, providing adequate logistic and technical assistance. The decentralisation of services would require the establishment of a well-worked out referral system to provide adequate expertise at the various levels to the organisational set-up nearest to the community, depending upon the actual needs and problems of the area.

18. Alternative Medicine

There is a remarkable growth in interest in alternative medicine among the public and health professionals. Various terms are used, but they all show that people are not fully satisfied with Modern (Western) Medicine.

Various therapies are included under alternative medicine. Among them are

(1) systems like Ayurveda, Homeopathy, Unani, Siddha, naturopathy

(2) herbal medicine, home remedies

(3) acupuncture, acupressure, magnetotherapy, manipulation, massage

(4) yoga, meditation, breathing and relaxation techniques, excercise.

The philosophies and techniques vary a great deal. The alternative therapies provide hope for patients who are not benefited by the Western (Modern) Medicine or do not wish to use that system of Medicine.

It is not irrational or unscientific to use alternative medicine. One major problem has been in evaluating the efficacy of the various procedures, drugs and non-drug therapies. Use of the established method of testing as is done in Modern -Medicine may not be relevant. Other models of health care having different conceptual framework may require a different approach in evaluation. But controlled trails are always necessary.

19. Holistic medcine

Holistic approach in medicine means the viewing of the person and his/her well-being from every possible angle. It includes

1. responding to the whole person (body, mind and spirit) in the context of the environment (family, community, culture, ecology)

2. use of a wide range of interventions (when indicated), procedures, drugs or non-drug therapies

3. participatory relationship between doctor and patient, giving the patient more decision-making authority.

Some people advocating 'holistic medicine' seem to reject Modern (Western) medicine and would go in for alternative medicine only. Holism would require openess to all including Modern medicine and alternative medicine.

III. THE INDIVIDUAL, THE FAMILY AND THE COMMUNITY

20.1. Every person is important. When a person is sick he or she must be cared for. Our response to sickness is healing the person, restoring the person to wholeness. The integrity of the person must be re-established as much as possible. There are many personal factors which account for differences in the susceptibility of different individuals, exposed to the same causative factors of disease, like the infections. carcinogeno, etc. The interaction between the host and the pathogen varies based on the individual's resistance, immunity, etc. Individual differences are seen in the variations in the manifestations of the disease. Many children are affected by poliomyelitis; only a few develop paralysis. The response to the same therpeutic measures also varies from person to person. Similar is the case with psychological problems. Each person is unique and we must pat all attention to him or her as such. But no individual is an island to himself or herself. He or she must be placed in the context of the family and the Community.

20.2. The family is the fundamental unit of society; it can be the basis for health action and healthful living. Most families in India, even in the present day society, remain faithful to the demands of love and solidarity. But families are exposed to the danger of becoming victims of selfishness and a technological and consumer mentality. The elders also can play an important role in preserving the health of the family. We should help in preserving the family and to live in fidelity to authentic

human values. This will have a profound effect on the physical, mental, social and spiritual well-being of the family and the community. Within the home are laid, in the minds of the people, concepts of health. Healthy living can be the outcome of learning from each other member of the family: Parent to child, child to parent and child to child.

20.3. The early christians lived as a community, caring for each other and sharing whatever they had. The solidarity of the community, sharing resources and responsibilities can lead to better health for all.

21. Community health

21.1. The Welfare and health of each and every member of the community was the concern of the early church. Our goal should be to develop healthy communities. Community health is a process of enabling people to exercise collectively their responsibilities to maintain their health; it is rooted in the people and committed to health-building through people's own action. "Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. Community health care is therefore part of the comprehensive pastoral work of the Church" - Cor Unum, 1978.

21.2. "Our hospitals must be community oriented, in contrast to being confined to within the walls, waiting for people to fall ill and come to us for repair" - Church in India Today, 1969. In order to do so, each existing hospital should start health extension programme in the surrounding areas. The health personnel, and especially the religious, working in the Church related institution should care for the general public around these institutions, visiting the houses and families, reaching out to the areas where health facilities are scarce or not available. Simpler medical care must be advocated wherever possible. The hospitals should serve in all areas of need and not shy away from fields like leprosy and the care of the mentally retarded.

21.3. An important part of Community health is a health environment. There must be concern for the environment: steady depletion, wastage and contamination; deforestation and defoliation. Unfortunately, greed, ignorance and apathy are making the environment health hazards.

21.3.1. Water gives life but it can also cause havoc if it is not fit for consumption. According to the National Environmental Engineering Research Institute, about 70% of available water in India is polluted. Most of the human waste are discharged directly or indirectly (untreated) into water sources. Another example of water unfit for human

consumption is that of 6000 villages in Rajasthan, where water causes sickness. Flourosis, a slowly incapacitating disease caused by an excess of flouride in drinking water, has already crippled permanently over 350,000 inhabitants of the desert belt; the progressive disease will cripple many more. Rivers, streams and ponds are polluted by various toxic chemicals which are discharged from the factories and industries and pose a serious threat to the life and health of the people who drink that water or eat fish which might have survived in that environment (most fish die).

21.3.2. Pollution of the air is very common and may be due to many causes. One such is pesticides sprayed widely in India forplant protection and for boosting production, as also for fumigation to protect food grains from damage. These pesticides and their intermediate products are highly toxic, posing serious threat to human health. Workers in pesticide factories are often exposed to them. Leakages during manufacture, distribution and storage can lead to fatal toxicity or chronic damage. Farm labourers and their families are exposed to the pesticides for long periods, during spraying operations. Residues are left in the food, like wheat, rice, pulses, groundnut, fish, milk and dairy products. Though many of these pesticides have been banned in other countries, they continue to be produced in India, or imported in increasing quantities.

21.3.3. Noise pollution is on the increase with greater mechanisation and transport. It is made worse by the indiscriminate use of loudspeakers.

21.3.4. Adulteration of food is proving to be a great hazard. Almost all food substances are being adulterated. One of the commonest items being adulterated is cooking oil. With the prices of edible oils soaring high, producers and sellers of edible oils are mixing non-edible oils with the edible ones and selling them as edible oils. The greed of a few is proving detrimental to the health of many. The same is true of dhal and many other food materials.

21.3.5. It is the duty of health workers to be knowledgeable and alert about the health hazards in the environment and to take action, along with community, to prevent the hazards. It is necessary to be vigilant and ensure that strict regulations for safety are passed and enforced. "India faces a disastrous 'double burden' of disease. Most old diseases continue to be rampant while new ones are making rapid strides" State of India's environment, 1982. The disaster in Bhopal was one such example.

21.3.6. The good customs and traditions in the community which have the accumulated wisdom of ages must be preserved and promoted. The confidence of the families and the communities in themselves and their ability to solve their problems should not be destroyed.

22. Primary health care

22.1. The Catholic Bishops' Conference (1978) had announced: "We want our health services to take primary health care to the masses, particularly in the rural (areas) and urban slums. Catholic hospitals and dispensaries should stress the preventive and promotive aspects of health care" Both rural areas and urban slums require primary health care. There is no need for city hospitals to go to far off villages to serve. The people of the urban slums cry out for our help.

There are three groups of factors which are detrimental to health in urban slums (Myths about Urban Health, Trudy Harpham):

1. Overcrowding; poor housing; density of insects and vermin; lack of waste disposal; poor personal hygiene, inappropriate weaning; inadequate diet.

2. Pollution; heavy traffic; stress.

3. Sociological and psychological instability and insecurity; single parent households; working women; neglect of children.

The member institutions can help by having extension work in the urban slums and rural areas surrounding their hospitals. These extension centres should focus on primary health care, giving importance to

1. health education, making each person and family an agent for change,

2. prevention, including universal immunization,

3. care for minor ailments given at the extension centre; and

4. referral to the hospital, when the problem cannot be solved there.

These extension centres should also mobilise the people to improve the facilities such as water supply and sanitation, improvement of housing and environment and provision of social amenities.

22.2. The Alma Ata Declaration said: "VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology. made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self

determination". The organisation of primary health care services must help each individual person in his or her own community. "The emphasis given to the new primary health care policy has shown the vital importance of a whole motivation approach on the part of those who work in the health field or for health improvement. Unless the new approach on the part of the personnel is inculcated through special courses that need thorough planning and implementation by highly qualified staff, the new orientation to be followed by the various health services will simply not come about" Cor Unum, 1978.

22.3. Primary health care is comprehensive health care, as the first element of a continuing health care process. It includes promotion of positive health by proper life style and health education. Ayurveda has always given priority to these aspects and particularly to the need for purity - Deha suddhi (purity of body), desa suddhi (purity of environment), ahara suddhi (purity of food), jala sudhi (purity of water) and mana suddhi (purity of mind). Health education makes each individual, family and community responsible for their own health - attaining it and maintaining it. Closely allied to it is the prevention of diseases. Primary health care includes the management of minor ailments, and the recognition and referral of illness, requiring further care. These engage more highly trained staff capable of dealing with a progressively wider range of health interventions. Primary health care also calls for rehabilitation, a sorely neglected aspect of health care.

22.4. Primary health care needs the training of a large number of community level workers. They work with the people. They may be selected from among the people of the community. In the case of the Catholic Church there are a large number of religious and lay persons working in the field with the people. These people are well-motivated; with training they can become the agents for helping the primary health care. The community health workers utilise simple technology appropriate to the situation and take cost-effective measures in providing primary health care.

IV. A CHRISTIAN HOSPITAL

23.1. With increasing responsibility being assumed by the Government in providing health care services, a question is sometimes posed: "Is there still a need for a Christian Hospital?" The answer is an emphatic "yes". This is because the Christian hospital provides something more than professional help, something extra of love, compassion and sacrifice. The Christian response to ill-health is the healing of the total person, restoring the integrity of the person, as much as possible. Healing involves a relationship with God. The total well-being includes

the physical, psychological and spiritual dimensions. The Christian Hospital should provide humanizing care, considering the dignity of the person. It should be an example against the depersonalising and debasing of the person. Christian health services must act as an inspiration to others.

23.2. In a Christian hospital, the professionals and other staff, the patients and the public are aware of the presence of Christ the Healer in the midst of the Community. Christ uses His ministers - doctors, nurses, chaplains, technicians, administrators, medico-social workers and, others - in His work of Healing. A Christian hospital gets its vitality from its own religious faith and system of values (Benedict M.Ashley and Kevin D.O'Rourke, 1977). The Christian hospital helps the patients and all connected to transform the experience of sickness and healing into an experience for personnal growth through suffering and redemption. All the people are united in a common bond and there is a spirit of prayer making it possible to receive more fully the Grace of God.

23.3. The Catholic hospitals are mostly owned and managed by religious communities or dioceses. There could be others like St. John's Medical College Hospital, established and managed through the efforts of the Catholic Bishops' Conference of India. The presence of Christ is celebrated through the sacraments and revealed through the Word of the Scripture. There are one or more chaplains, who help by pastoral care and counselling of the hospital community, including the patients and the staff.

23.4. A Christian hospital is committed to serve the underprivileged and neglected. It has to be community oriented and fully supportive of primary health care. It should meet the health needs of the poor.

23.5. A Catholic hospital has to provide efficient health care. There is need for competence.

23.6. Christian hospitals should avoid any form of rivalry with other health care institutions, governmental or non-governmental. Each must be supportive of the other so that the health needs of the people are met.

23.7. The Catholic hospital has to observe ethical norms according to the teachings of the church. Many issues come to the fore-contraception, abortion, (family planning and responsible parenthood) euthanasia, and many others

24. Personnel

24.1. The quality of health care services depends on its personnel - their general education, job specific training, dedication to the

profession, and commitment to the people. The greatest problem is the shortage of dedicated personnel. The training, while based on science, needs orientation towards the social, cultural and economic conditions of the people. The knowledge, skills and services must be defined based on the requirement in the field. Periodic renewal bringing out the spiritual dimensions, is a must for all persons working in the Christian health care services.

24.2. The 2500 Catholic health care institutions need the services of a large number of personnel of various categories, for the hospital care and community health programmes. We do not have the data necessary to make any realistic assessment of the needs of these health care institutions at present and in the future. We need answers to the follwing questions.:

i. What is the profile of the available human resources in our hospitals?

ii. What are we doing at present? Are the available personnel adequate?

iii. What should we be doing?

iv. What are the changes planned?

v. What is the manpower needed, quantitatively and qualitatively to meet the present and foreseeable future needs?

The training has to be such that they are competent and imbued with the Spirit of service and the newer philosophy of serving all and particularly the deprived and unreached.

(1) Community health workers: St John's Medical College had a programme of training community health workers and a number of batches (mainly religious sisters) have been trained and are working in the field. The number thus trained is necessarily small.

The Catholic Hospital Association of India has taken this up now and it should be possible to have adequate number of community health workers trained and available for service, even in the remotest parts of the country.

These Community Health Workers need the support of the hospitals.

(2) Nurses: The Catholic Hospitals have been training a large number nurses for a long time. The training has been good but many

of them have gone abroad and are not available for service in India. It is necessary to motivate them to serve in the country, inculcate the love of the country and the mission to serve. It is also necessary to train large numbers in more institutions and especially the religious sisters, who are happy to serve anywhere in the country. The training of nurses is being more and more community oriented and this has to be given greater momentum.

(3) Doctors: Because of the enormous expenses involved in the training of a doctor it has not been possible to have another Catholic Medical College or increase the intake of the existing college, even though there is a felt need. The output is small and all of them are not available for service on a continuing basis for service in our institutions. It is necessary to motivate the graduates to remain in the country and to serve in the rural and other unserved areas, on a continuing basis, working out a career structure for those with post-graduate qualifications and those without. It is also necessary to meet their professional needs and the educational and social requirements of the family.

Recently a Homeopathic Medical College has been established at Mangalore as part of Fr. Muller's Charitable Institutions. The graduates of this college will soon be available for service in the country.

(4) Dental surgeons, dental hygeinists, opticians and refractionnists are also needed in fairly large numbers to provide care.

(5) Pharamacists: There is a dearth of qualified pharmacists; this is more so in the Catholic Hospitals. If the concept of rational drug therapy and essentiai drugs is to succeed (against the powerful, advertising techniques of the industry to market all kinds of drugs) it is necessary to have fully trained pharmacists. We need more training centres.

(6) Laboratory, X-ray and other technicians: We must have more of trained people to provide dedicated service in the periphery. There is shortage of well-trained technicians and this dearth can be a hazard for the proper management of patients. The training itself has to be oriented to meet the needs of the community and not merely the larger hospitals.

(7) Other health workers: There is need for many other categories of health workers like medicosocial workers and dieticians and their training must be undertaken.

(8) Health Administrators: Health Administrators must be competent. Training in health and hospital administation is a must, if we are to provide comprehensive health care. The present state of administra-

tion is unsatisfactory and inefficient as ad hoc arrangements are made and persons without aptitude, training or experience are put in charge. It is also necessary to ensure that the admistrator imbibe the philosophy of community health, if the newer programmes are to succeed. A programme of training in health and hospital administration has to be started. "More specialised education is needed. Courses are needed for top level health planning and administration; likewise for middle management, especially in areas such as finance, purchasing and accounting" - The Church in India Today (1969).

The new health policy alters the roles of the health professionals but does not make them less essential. The training should enable them to work as effective members of the health team, coping with the challenges of maintaining health, caring for the sick and also getting involved in removing underdevelopment.

V. SPIRITUALITY, PASTORAL CARE, CHAPLAINS

25.1. The spiritual dimensions of health care are often pushed to the periphery even in our Catholic Institutions. Medical knowledge and efforts today do not often have a total view of the human person. There is an emphasis on the physical aspect of human existence while the mental and particularly the spiritual aspects are ignored. In the mad rush for so-called modernisation and technology we tend to forget the eternal values. India has a strong spiritual heritage. The church and church related institutions must foster it, understanding the higher purpose of life. We should see in each person the divine presence; this will make us see him as a person created in the image of God and not at a broken down machine, needing repairs.

25.2. As the restoration of the people to wholeness is our aim, it is necessary to care for the whole person. Neglect of the spiritual care can be disastrous. Pastoral care must be an integral part of health care to this aspect of healing. There is need for chaplains and others who can help. We have to undertake the training of a large number of hospital chaplains. In addition, every priest and religious could be trained in the basic concepts and principles of total health care.

25.3. Our health personnel need a new orientation. There is need for greater reliance on the divine aspects of healing and the efficacy of prayers.

25.4. It should be the endeavour of the health care institutions and the Church to develop human resources such that they can be of better service and also their aspirations for improvement can be met.

26. Pastoral care

A department of pastoral care can be extremely useful in a hospital Many people can be involved in this work. Pastoral care must be teamwork to be effective. It involves chaplain, doctor, nurse, medicosocial worker, other staff and volunteers. It would be ideal if they are trained to work together. In any case, they must have frequent meetings and exchange ideas, to be effective.

The pastoral care team works for the total good of the patient, their relatives, the staff and their families. A pastoral advisory committee consisting of representatives from various sections of the "hospital community" can help. Religious sisters either from the same hospital or from outside the hospital can help a great deal. The members of the pastoral team must visit regularly the patients, listen to them and provide emotional support to the patients and their families. They pray for the sick and with the sick and their families. They must be warm and sympathetic towards the patient. The same applies to staff and their families, needing support and guidance. The team provides relief from loneliness and isolation.

27. The Chaplain

An integral member of the healing team is the chaplain. Healing is multi-dimensional and each member of the team has something unique to contribute to the total healing. The chaplain contributes to the ethical values and the Christian dimensions of health care.

The Chaplain must be trained specially to minister to the patients and the hospital community. Unfortunately there are very few training programmes for Chaplains in the Catholic hospitals. There is urgent need for such training programmes as the hospital is a special situation.

The Chaplains visits the patients and especially those in greater need - the seriously ill, the patients going for major operations and other procedures and those who are anxious, afraid and have feelings of guilt.

The Chaplain emphasizes the dignity of the individual and that God cares for each person. He/she helps by contacting other members of the team, giving better care. He/she gives spiritual orientation to all the staff - doctors, nurses and others.

The Chaplain administers the sacraments regularly and in times of crises. Patients are provided the opportunity of participating in all the sacraments. He/she helps in solving, along with others, problems of an ethical nature.

The Chaplain assists the families of patients at the time of death of patient. He/she helps in arranging for patients of other faiths to get spiritual help from their own priests, as and when needed.

VI. AREAS OF SPECIAL CONCERN

28.1. Infectious diseases (caused by viruses, bacteria, parasites, worms) account for the largest number of deaths and morbidity in our country. We have the know-how to tackle them and yet we do little to reduce the incidence of these diseases, even though they have been mostly wiped off in many countries. The expanded programme of immunisation is expected to deliver the goods in the control and eradication of some of the major infectious diseases. The Catholic health care facilities should fully-co-operate in this endeavour.

28.2. Tuberculosis is rampant in the country and is one of the major killers and also responsible for a great deal of morbidity. We have not been successful in controlling it. Since BCG vaccination has not proved to be very effective in preventing adult pulmonary tuberculosis, case finding and case holding are most important. Our Catholic health care institutions, co-operating with the Governmental efforts and probably utilising the shorter therapy, can help in case-finding, case holding better compliance and more complete treatment.

28.3. Leprosy is a socio medical problem, even though it is like any other disease and can be cured. While many of our hospitals and health personnel have been in the forefront in trying to tackle this problem, some Catholic Institutions are reluctant to treat these patients. This situation must change. The Catholic health care insistutions must make renewed and vigorous efforts with the multidrug therapy to reduce the incidence and prevalence of this disease.

28.4. Blindness is also a big scourge. It is estimated that the incidence is about 1.4% of the total population. Most of it is preventable with adequate intake of Vit. A and remediable with cataract removal.

28.5. Accidents are among the ten highest causes of death; they also result in disability and loss of income. The care of the injured needs special care and our Catholic hospitals should not be afraid of taking the victims for fear of medicolegal complications and getting involved in court cases. It is precisely in such accident cases that we can do a lot of good because

1. an immediate care can make the difference between life and death or life-long disability.

2. We can witness with integrity, not influenced by power or corrupted by bribery.

It may be that we would not like to be involved in cases such as assault due to union rivalry and similar ones. Such cases can be directed to the nearby Government hospitals, of the time taken to reach there and get care is reasonable in the particular instance. In all accident cases, we sholud take them only if we have the competence and resources to manage them adequately.

28.6. Diarrhoeal diseases are widespread and often with fatal or serious consequences. It need not be so, especially now with the easily available oral rehydration therapy. A large number of people, especially in the rural areas, have no dependable access to sufficient, safe drinking water and much less so to sanitary facilities. The long-term effort should be to ensure adequate safe drinking water and sanitary disposal of waste.

28.7. Undernutrition afflicts many millions. It is one of the main causes contributing to the high infant mortality rate (average 105, with only 35 in Kerela and 150 in U.P.) and young child death. Infants who survive have problems in development. Undernutrition reduces the energy, undermines performance, and achievement in social and work place and reduces resistance to disease.

28.8. Mental health

A much neglected group of individuals in Society is the mentally handicapped or ill persons. The number of people affected is very large; yet, very little is done to alleviate the suffering. There are

(1) the mentally handicapped, with arrested or delayed development. The level of functioning is limited. There is need for additional support from the family and the community over long periods of life.

(2) the mentally ill. Among them are the chronically mentally ill and those with acute psychiatric problems.

The management of mental health problems has shifted largely from the specialised mental hospitals to the general hospitals and the community care services. Mental handicap should be prevented as far as possible by good pre-natal, intranatal and post-natal care. The management of the mentally retarded, mentally ill and the epileptic needs a therapeutic community, giving mutual help and support.

28.9. AIDS

Acquired Immune Deficiency Syndromme (AIDS) has been spreading rapidly. At present, it has a mortality rate of almost 100%. The fear of contagion and risk is causing an attitude of rejection. Yet, all those who suffer deserve attention and loving care. There is need for institutions which will welcome them. Prevention is best and calls for correction of permissive habits and sexual promiscuity. Human sexuality within the sphere of marriage can prevent the spread of disease, which is often caused by having sexual relations with many partners, and homosexuality. The disease is also common among these who are addicted to narcotics, through the use of needles for injection. Weaning away from drug addiction helps. The awareness of these factors must spread through health education.

28.10. Venereal diseases are highly prevalent in many countries including ours. We must take active measures to detect, treat and prevent them. Health and sex education can help greatly in preventhing the spread of disease. Promiscuity leads to spread of infection.

29. Special Categories

29.1. Among specific population groups, the protection of the health of mothers should get priority, because of the special biological and psychological needs inherent in the process of human growth, which must be made to ensure the survival and healthy development of the child. "Motherhood and childhood are entitled to special care and assistance" - says the UN universal declaration of human rights (1948). A substantial improvement in the overall health of the people can be brought about by such care. For women of the reproductive age, pregnancy-related complications are among the most common causes of death and morbidity, with infection and poor nutrition increasing the risks of low birth weight and neonatal mortality and morbidity. Promotion of breast feeding should be an important aspect of the health education of the mother. Breast feeding gives adequate protein - rich food as also protection against many infections. Breast feeding offers the best possible start in life for all children. Breast milk is ideal in composition for the growing baby, being far superior to any manufactured product. It is fully adequate for the first four months, helping in healthy emotional development and bonding. When supplementary food becomes necessary after 4 months, home-prepared foods must be given. The parishes, Catholic teaching institutions and hospitals, can play an effective role in ensuring adequate nutrition of the child and the pregnant and lactating mother.

The promotion of baby foods should be discouraged. Aggressive marketing tactics by the manufacturers of baby foods has led to a

culture where mothers consider that their babies will thrive better with such artificial foods. This is far from the truth.

29.2. The process of aging is a normal one but it produces increased risk of disease. It can produce psychological problems and feelings of loneliness and not being wanted. Geriatric care needs to be developed. The interaction of the older members of the family with the younger members, in particular children, can have a beneficial influence on the health of the family.

29.3. Christ devoted considerable amount of his time to heal the disabled - the blind, the lame and others. About 10% or approximately 70 million people in India have some disability or other. The disabled are equally children of God; they are living witnesses of Hope. We have to pay special attention to the disabled and particularly the mentally retarded and mentally ill. Christ paid the same price for all.

30. Research

Our hospitals have not been known for their research work. They may not be in a position to do fundamental research nor is it expected from them. But our hospitals must be involved in applied and epidemiological research, using simple. low cost, easily applicable methods and technologies. This would also help in identifying priorities in health care and monitoring and reporting on morbidity in the area. Data collection and reporting to the appropriate authority are vital if we are to improve our health care. The teaching medical institutions and larger hospitals have a major role to play in research.

31. Communication

In order to be effective in our endeavour for better health, it is necessary to communicate effectively. Communication is a two-way process, whether it be between two individuals or between groups of persons. It is mutual. The people must share the idea before they can communicate with each other. All bring into the relationship their thoughts, feelings, behaviour patterns and points of view. Communication requires that the persons involved permit themselves to understand the other person(s). This occurs best when there is empathy.

Each person receives the signals, verbal or non-verbal and interprets them. The same stimulus may be interpreted differently by different persons. It is important that the signals are interpreted correctly for proper interpersonal communication.

Communication can serve different purposes. It can be social. In health care, it can be therapeutic. Patient education requires good

communication. Health education needs effective communication. A judicious mix of purposes of communication helps a great deal.

One of the main barriers to good communication is language. It is necessary to be proficient in the use of local language. But verbal communication is not the only means of communication. Other forms like touch, body language, etc could be used effectively. They can be improved upon by learning and practice.

A major problem met with in the Catholic Hospitals is that of language. This is especially so in the case of hospitals established by the religious sisters in areas other than their domicile. The personel are transplanted to the new location, where the language can be different. It must be ensured that the health personnel have proficiency in the language of the place. While such proficiency is lacking, efforts must be made to train the personnel in the local language.

32. Disaster relief

32.1. Calamities, natural and manmade, strike the people and it should be our duty to provide relief quickly and adequately. Thought must be bestowed to the establishment of a network of Mobile Catholic Relief Organisations, which will always be in readiness to rush to the help of the people afflicted. An adequate help in time can markedly reduce the suffering and even the quantum of help needed.

32.2. It should be possible to survey health hazards in the area such that tragedies like those of Bhopal do not occur. Once the hazards are located, people's consciousness can be raised and efforts made to remove or reduce the hazards of dangerous industries, like those producing pesticides.

33. International Co-operation

As part of the Universal Church, the Church in India should collaborate in the health care everywhere. With their scarce resources, the Catholic Health Care Institutions are to a greater or less extent, still receiving help (mostly in financial terms) from the more affluent countries. This is necessary at present but such help must be tapered off as regards routine hospital care. The International Funding Agencies could help CHAI and its members as partners in Health and Development. So also, the member institutions, with their health personnel and know-how can help other countries which need such services.

VII. USE OF DRUGS AND PHARMACEUTICALS

35. The large majority of people who need or seek care or cure from the member institutions of the Catholic Hospital Association of India (CHAI) suffer from infections, diseases arising from malnutrition. lack of supply of drinking water and sanitation, polluted environment, accidents, wrong life-styles and lack of primary health care facilities. The requirement is safe drinking water, better sanitary disposal of wastes, protection of environment, health education, adopting healthy life-styles and prevention of diseases. Many of the problems which bring about illness have social, economic and cultural bearings. Solutions to these major problems are necessary but take time and great efforts. Meanwhile, the health care Institutions have an immediate end effective role to play. This has many facets, one of which (an important one) is the proper use of drugs and pharamaceuticals for cure of disease, alleviation of symptoms and prevention of disease. Judiciously used, along with non-drug therapies, they can be highly beneficial.

35. Every hospital must have its own policy for the rational use of drugs and pharmaceuticals. The policy must be people oriented - for the benefit of the individual, the familiy and the community. Today we have many potent drugs which are highly beneficial, if properly used. But they can do considerable harm, if improperly used. There are also many useless and ineffective drugs and hazardous combinations of drugs. The drug policy of the hospital should prevent the exploitation of the hospital (and through them, the people) by the drug manufacturing firms - pushing their products by all kinds of gimmicks, gifts and temptations and the "hard sell" by the company representatives.

36. **Hospital Pharmacy:** Whether large or small, each hospital dispensing drugs should have qualified pharmacist(s), who manages the hospital pharmacy efficiently, providing competent and caring service. The pharmacist

(i) identifies the drugs required for the hospital, considering

a. quality
b. economy, and
c. availability,
and places proposals before the drug committee for selection;

(ii) procures the selected drugs

a. at minimum price,
b. in the right form and quantity, and
c. at the right time;

(iii) stores the drugs under appropriate conditions so as to maintain
a. potency, and
b. quality;

(iv) arranges for

a. pre-packaging,
b. compounding, and
c. dispensing.
adopting scientific, legal and ethical principles;

(v) uses proper inventory control;

(vi) initiates and implements policies for supply within the hospital;

(vii) wherever indicated and feasible, undertakes the manufacture of pharmaceutical formulations, such as intravenous fluids, following all the rules and regulations and quality controls;

(viii) arranges for the routine checking, including weeding out of date-expired drugs and analysis of drugs; and

(ix) maintain the various registers, as required by law and necessary for information, follow-up and action.

The pharmacy will have a small library of books, monographs. and leaflets, dealing with professional, technical. legal and other matters, The pharmacy will also subscribe for relevant journals.

37. **Drug Committee:** It is essential to have a drug committee In its simplest form, in the small hospital, it would consist of

(i) the hospital administrator,
(ii) the doctor,
(iii) the nurse and
(iv) the pharmacist (secretary)

If there is a medical superintendent, he/she will also be a member. Depending on the size of the hospital, more members can be added, without making it unwieldly. The optimum number may be kept at 7. The drug committee will have the following responsibilities:

(i) formulate the drug policy of the hospital
(ii) prepare the drug list for the hospital
(iii) review and update the list periodically
(iv) monitor drug reactions

(v) disseminate information regarding

a) administrative and professional policies, and
b) availability of new products and formulations, together with adequate data regarding indications, adverse reactions, interactions and contra-indications.

The drug committee should meet often in the initial stages and later on less frequently (say, once in 3 months). There will be requests for additions (in the light of newer, more efficient drugs becoming available, experience, change in personnel and services) and suggestions for deletions. The drug committee should aim at keeping as small a number of drugs and formulations as possible, without sacrificing efficiency; this will ensure a reduction in stock and money tied-up as also greater efficiency in management. The drug committee could publish occasional newsletters or bulletins, giving information regarding

(i) developments in drugs and pharmaceuticals,
(ii) medical and nursing implications in the use of certain drugs and in specific situations.

38. **Choice of drugs:** The choice of drugs depends on

(i) prevalent diseases,
(ii) treatment facilities,
(iii) available personnel, and
(iv) financial resources.

The drugs selected should be efficient (effective with good cost benefit ratio) and safe. It is necessary to ensure quality. It is a fallacy to think that the more reputed firms automatically produce better quality drugs. Many of these larger firms give contracts to small scale firms and the products will not have any better quality. Quality control can be achieved by

(i) W.H.O.certification scheme regarding the quality of pharmaceutical products on the market
(ii) Good manufacturing technology
(iii) product information, based on the basic studies and clinical trials carried out by and on behalf of the manufacturer, analysed critically and
(iv) samples sent to an independent reliable analytical laboratory.

It is also necessary to ensure stability and bio-availability. The drug must have keeping quality under the environmental (temperature, humidity, etc) conditions. Bio-availability will be determined by, among

others, the fraction of the dose of the drug that enters the systemic circulation. There can be difference in the rate of dissolution or of solution of the formulation and also in the rates of completeness of absorption of the drug from the gastro-intestinal tract. Drugs which are taken by mouth may be metabolised to a greater or less extent during the passage through the liver (first pass effect). The blood concentraction will be less to that extent, compared to intravenous administration. Added to this will be factors like differences in peripheral utilization.

39. Drug list: The list should include all those drugs required to satisfy the health needs of the large majority of patients for whom care (out-patient or in-patient) is provided by the hospital or health care facility. It should also include drugs in common use required in emergency. The drugs in the list should be available at all times in adequate amounts in the appropriate dosage forms. At the same time, the medicines listed should be limited. The average doctor uses only a small number of the drugs. He or she cannot be expected to know the details of the thousands of drugs and their formulations in the market. The availability of so many different drugs and formulations and the use of similar names for different drugs or different names for similar drugs entails danger to the pubilc. It creates and increases the chances of error.

All drugs listed will be in *generic* names. The custom of usage of brand names has posed very high barriers to market penetration by equally effective but cheaper drugs. The expensive promotional activity of the manufacturers boosts up the cost of medicines. The greater utilization of generic drug names can lead to lower prices.

To start with, the list of essential drugs prepared by WHO may be used as a basis. A list adapted from it in the light of experience in the Indian situation is given in *Chapter X*, which should be modified to suit the requirements of a particular hospital and the local situation. The individual drugs are grouped into broad pharmacological and therapeutic categories. All those who prescribe medicines in the hospital should stick to the list; ordering medicines outside the list should be done only in exceptional cases. There should be all relevant information (concise, accurate and comprehensive) available:

(i) International generic name
(ii) Pharmacological effect and mechanism of action
(iii) Clinical indications
(iv) Average dose and duration of treatment, range for children; dosing interval; special situations such as renal, hepatic cardiac and nutritional insufficiencies.
(v) Contra-indications.
(vi) Precautions, especially in situations like pregnancy, lactation, etc.

(vii) Adverse effects
(viii) Drug interactions.
(ix) Effects of overdosage; therapy - general and specific.

39.1. There are many drugs which are banned by Government of India. Yet they continue to be produced, marketed, prescribed and administered. It is necessary that the drug list (formulary) of the hospital should not contain any of them.

39.2. There are certain other drugs which are banned in many other countries but not banned in our country. There are still others whose use has to be severely curtailed. The drug committee should carefully consider whether such drugs should be included in the formulary.

39.3. Depending on the policy, traditional medicine may be included in the list. This should be done only if the doctors are conversant with such medicines and have the relevant information. Of particular importance are medicines in Ayurveda, Siddha and Unani. Large scale production of Ayurvedic drugs is now undertaken by many pharmacies in the country. Ayurvedic medicines prepared are in the form of distillates (arka), fermented preparations (asava and arishta), linctus (avaleha), incinerated matter (bhasma), powder (churna), ghee (ghrita), tablets (vatigutika), decoction (kwatha) and others. The siddha medicines use mercury, sulphur, iron, copper, gold, arsenic and other minerals as well as vegetable poisons; care must be exercised in their use, particularly by those not trained in the Siddha tradition. The Unani medicines consist mainly of herbal but also include animal, mineral and marine drugs, used either singly or in the form of decoctions, infusions, tablets, powders, confections, syrups and aquas.

39.4. We have to be equally careful when we use medicines belonging to other systems. Sometimes the socalled "ayurvedic" medicines may contain drugs used in modern medicine. It is necessary to know the constituents. A popular "ayurvedic" anti-asthma medicine had large amounts of aminophylline and steroids in it but not made known to the users.

39.5. **Procurement**: Drugs may be obtained from different sources; it is necessary to have a procurement policy. Drugs may be obtained by bulk purchases, small purchases and as gifts. Considerable savings can be effected by strategic purchase policies. If there is a central purchasing agency on a national, regional or diocesan level, the drugs can be obtained at reduced prices by purchasing in bulk quantities and repacking in small quantities to be supplied to member institutions, using effective but less costly containers. Another method is to order in bulk for the requirements for a whole year but to be supplied in small quantities at stated intervals.

40. Meeting with representatives: The drug committee should lay down a policy as to when and how the representatives can meet with the medical and pharmacy personnel. This should be aimed at a three-fold objective:

(1) to get valid and reliable information about new drugs and formulations,
(2) to avoid wastage of time and
(3) to reduce the high pressure salesmanships with free samples and gifts for the individuals to influence their decisions.

It would be better if the representatives meet the hospital personnel in groups, so that scientific and valid information can be given, questions asked and clarifications obtained. This would ensure that ineffective products are not given to patients who could have been treated better with more effective or safer drugs or with no drugs at all.

41. Storage: The drugs must be stored properly. Those which require refrigeration must be stored carefully in refrigerators and the temperature of the refrigerator checked every day. Schedule drugs must be kept as required by law and proper registers maintained.

Bin cards must be prepared. The cards should give full details of date of order, price, vendor's name expected date of delivery, quantity ordered, quantity received and expiry date. Drugs with expiry date must be monitored carefully.

Poor security in storage can lead to major loss through pilferage.

42. Management. The purchase and distribution of the drug must be managed efficiently with respect to the quantity stocked (minimum and maximum), order quantity, lead time and ensuring continuity of supply. There is need to prevent overstocking, maintaining the stock at the optimum level, reviewing past records of requisitions and utilization and changes in services and availability of drugs. Inaccurate estimates can lead to overpurchase and spoilage or to underpurchase and out-of-stock situation. "First-in, first-out" policy may be followed ;this would ensure that the drugs, even with short shelf-life, move sufficiently quickly. Training should be given in proper materials management.

43. Costing: There may be conflicting interests in costing the drugs-humanitarian and the need to have a 'margin' to meet the expenses. The usual method is to mark up the price above the purchase (wholesale or hospital) price by a certain percentage, keeping the final price (as given to the patient) within the usual retailer's price. This method may be given up and replaced by adding a fee-for-service to the cost; this would prevent the tendency to go for costlier medicines as they would give a higher gross margin. The tendency, if it exists, of making a profit from drugs

to meet "other expenses" must be curbed as it may lead to prescribing more medicines than needed. A better way would be to charge for consultations.

44. Prescribing: The following points must be considered while prescribing:

(i) Does the condition of the patient require a drug at all? Or, does the patient need advice? Sir William Osler, father of modern medical practice said: "One of the first duties of the physician is to educate the masses not be take medicine". Drugs are being prescribed unnessarily for a number of conditions, where non-drug therapies may to better.

(ii) Is the safest and simplest medicine being prescribed for adequate duration and no more? The doctor must balance safety and efficacy against the hazards. It is necessary to prevent iatrogentic diseases; the simplest effective drugs with minimal toxicity must be prescribed. Particular attention must be paid for the effects on the unborn child, while prescribing for the pregnant woman. Caution must be exercised when prescribing drugs for the elderly and in cases of kidney and liver dysfunction.

(iii) Has the patient been informed of the possible adverse reactions? This is particularly important in the ambulant patients.

44.1. **Poly-pharmacy** (prescribing many drugs for one disease) must be avoided. Polypharmacy indicates

(i) lack of knowledge of the action of the drugs,
(ii) inability to critically diagnose the condition and evaluate therapy,
(iii) lack of confidence on the part of the prescriber,
(iv) exploitation by the drug industry, and
(v) gullibility of the public (especially with respect to tonics, vitamins and other nutritional formulations).

Many formulations contain more than one active ingredient. The advantage claimed is better compliance. But the combinations are often irrational; they lack flexibility; some of the components may be unnecessary and the drugs may even be incompatible.

45. Adverse drug reactions

Modern drugs are powerful. If used with skill and wisdom, they can be highly beneficial; but they can cause serious adverse effects, if

care is not exercised. Some risk is always present. We should be always on the lookout for adverse reactions. Most of the adverse reactions are manifest immediately or within a few hours or days of administration of the drug but some can be delayed very much.

Many groups of drugs are prone to cause adverse reactions. Some do so more commonly. It is important to be aware of the possibilities of risk and to be constantly on guard.

VIII. CHOICE OF TECHNOLOGY

46. Health care is expensive. In the present conditions in India, the large majority of people who need health care services often cannot afford to pay for the services. It should be the endeavour of the Christian hospitals to reduce the cost. Diagnosis and management must be cost-effective and simpler. The burden on the people must be reduced.

47. Catholic health care institutions are run on a 'no-profit' basis. Almost all institutions have deficits, large and small. The deficit is made up by donations from persons of good will. When resources are limited, every effort must be made to allocate them equitably. The allocations must ensure the maximum good to accrue to the maximum number of people and to the most needy. Choices have to be made; these are not easy.

48. We must use technology which is relevant, appropriate and cost-effective. India has a large infant and child mortality rate. This problem can be tackled by a group of simple interventions: antenatal check-ups of the pregnant woman (with immunization by tetanus toxoid and nutritional supplements, if indicated), immunization against the common childhood infectious diseases, oral rehydration therapy for diarrhoeal diseases and better nutrition with growth monitoring for the growing child. Procedures like immunization are really high technologies, as they demand the production of effective vaccines whose effects last long, giving almost life-long protection. Contrary to this, such sophisticated technologies as coronary bye-pass surgery, etc are half-way technologies.

49. The benefits of costly technology often accrue to a smaller and more privileged group. The hospital has to make the right long-term decisions. With limited funds, if a large allocation is made for the purchase of a costly equipment with high recurring costs, we may deprive a large number of needy patients. We should be able to provide the minimum acceptable level of health care to all.

50. Technologies which are appropriate in affluent countries where manpower is costly, may not be suitable in India. The use of disposal items is one such. There is clamour for disposable syringes. Because of the cost involved, we do not discard them after one use but continue to use them repeatedly causing spread of infection. Disposable articles (Sterile at the first use) must be disposed off after use.

51. Assesment of technologies should include the potential need and the relevant constraints like availability of trained personnel. It is sad to see sophisticated, costly equipment bought at great cost lying idle because of non-availability of trained persons or because of lack of spare parts.

52. Tho choice of technology is crucial to the philosophy and objectives of the hospital. It affects the priorities, target groups investment level and the character of the personnel. A higher level of technology requires a larger investment; it needs a more highly trained specialist and technologist, whose services can be had only at a higher price. "Pressures lead to the use of equipment that may be inappropriate, not cost-effective, presented to the market place too quickly and often inadequately evaluated Competetions between firms forces them to use selling pressures which affect users. High innovation can mean costly, early obsolescence and the desire for prestige can distort ideas about the real usefulness of the equipment" - High Technology around the World - International Hospital Federation Yearbook, 1987.

53. Hospital administrators are often caught in a dilemma. They are often pressurised from different sectors to buy new costly machines. Five criteria must be applied in the selection of technology:

1. Diagnostic value: Will this new equipment improve the diagnostic capability significantly in terms of greater accuracy reduction of time, etc, to the advantage of better patient care? If the advantages are only marginal which will not affect significantly patient care, there will be no justification in buying much more costly equipment.

2. Therapeutic usefulness: Will this technology bring about better treatment and management of the patient?

3. Health outcome impact: Will this technology bring about quicker restoration of the health of the patient? Will that restored health be maintained longer?

4. Patient acceptance: Is the new technology acceptable to the patient? Is he willing to undergo the procedure for improvement of quality of life?

5. Economic implications: The cost is important to the patient and the hospital. Is the cost too high, pricing out most of the would-be beneficiaries and those whom the hospital would like to serve?

IX. ETHICS

54.1. Every major social change brings about a confrontation with its values. Health personnel and health care facilities are constantly confronted by ethical problems. The availability of contraceptives and sterilization, legalised abortion, amniocenteses (for avoidance of the birth of children with certain defects; selection of sex of the child to be born), genetic engineering and manipulations, life-supporting systems, transplantation of organs, euthanasia, control of human behaviour (psycho-surgery and psychotropic drugs), human experimentation (individal good vs common good), the rights for health and health care - all pose problems which are difficult to solve. It is necessary to evolve and frame proper code of conduct for the health professionals and for the hospitals, such that they do not indulge in practices which are morally and ethically wrong or questionable. These codes of conduct will give the guidelines to help the people take the appropriate decision.

54.2. We have a number of guidelines for the doctors, nurses and others, starting with Hippocratic oath, Geneva oath and others. Perhaps we can codify them into a new and appropriate oath, affirming our oath faith in God carrying out the mandate, protecting life in all its stages and all circumstances from the moment of conception, respecting human dignity and helping people to attain health in its totality.

55. Human life is of pre-eminent value. It is a loving gift of God and must be protected from the very moment of conception, through prenatal life, at birth, in the growing child, in old age; it must be preserved in pain and suffering in the physically disabled and the mentally retarded, in the socially outcast, in the addicted and in the economically disadvantaged. The various religions in India hold life as sacred. The Second Vatican Council said: "Whatever is opposed to life itself, such as type of murder, genocide, abortion, euthansia or wilful destruction. whatever violates the integrity of the human person, such as mutilation, torments inflicted on the body or mind, attempts to coerce the will itself; whatever insults human dignity, such as subhuman living conditions, arbitrary imprisonment, deportation, slavery, prostitution, the selling of women and children, as well as disgraceful working conditions where men are treated as mere tools for profit rather than as free and responsible persons; all these things and others of their like are infamous indeed . . . . . they are a supreme dishonour to the Creator".

56. From the moment of conception, human life must be guarded with the greatest care. All deliberate action, the purpose of which is to deprive the embryo or fetus of its life, is never permissible for any reason. However, medical means urgently required to cure a grave pathological condition in the pregnant woman and which cannot be prudently deferred until the fetus is viable are allowed even though it might endanger the pregnancy in progress. Catholic hospitals are not to provide abortion services even under the so-called principle of material co-operation.

57. In vitro fertilisation is unnatural and violates the dignity of the persons and of marital and parental relationships. It also has many risks inherent in the procedures and of superovulation and surgery. There is intentional destruction of the embryoes (flawed and surplus). In vitro fertilisation separates the unitive and procreative aspects of the conjugal act.

The moral problem with in-vitro fertilisation is that procreation is not dependent upon the sexual act between two married people.

58. Abortion is carried out legally and illegally for various purposes, including unwanted pregnancy and sex selection. Female foeticide is carried out using ammiocentesis, followed by abortion.

59. No one may attack the life of an innocent person, without thereby resisting the love of God for that person. Suicide is just as wrong as homicide. Such an action must be regarded as a rejection of God's loving plan. Medical personnel should not assist a person in such an act.

There are many advocates for euthanasia. There are two opposing key ideas:

"1. The individual should control his own destiny.

2. In many situations, the patient is not able to make the relevant decisions; leave the choice to others who are able to decide, better informed and less involved" - Maurice Rochaix, Hospital laws and ethics, International Hospital Federation Yearbook, 1987.

Euthanasia as understood as ' an action of omission that by its nature or by intention causes death with the purpose of putting an end to all suffering" is wrong, even when the patient asks for it. The pleas of the very seriously ill, as they may at times beg to be put to death are hardly to be understood as conveying a real desire for euthanasia. They are almost always anguished pleas for help and love. The medical personnel are called to respond with love and care not by putting an end to the persons' life.

60. While one is bound to use ordinary means to preserve life, one is not bound to use extraordinary or disproportionate means. A correct judgement is to be made by weighing the type of treatment, its difficulty and danger, and expense against the results that can be expected in the light of the sick person's condition and resources of body and spirit. When death is imminent and cannot be prevented by the remedies used, it is proper to decide to renounce or terminate treatment that can only yield a precarious and painful prolongation of life (or rather of the dying process). To reject ordinary means of prolonging life is equivalent to euthanasia.

61. Suffering endured in union with the Passion of Christ has a salvific value. However, in the case of many people, human and Christ tian prudence urges the use of such medications as may alleviate or eliminate suffering, even though they cause secondary effects such as lethargy or diminished awareness. If there is no other means, the removal of pain or consciouseness may be done by the use of narcotics that may shorten life provided the action does not prevent the fulfilment of one's urgent moral and religious duties before death. Painkillers which cause loss of consciousness call for special caution as they might prevent the fulfilment of moral obligations and familial duties as well as disposing one for the final meeting with Christ.

62. Whenever an invasive diagnostic or therapeutic procedure is being undertaken (surgery, biopsy, peritioneal dialysis, etc), it is necessary to inform the patients as clearly as possible of the implications of the procedures and get the informed consent. Proceeding against the patient's wishes is to fail to respect that person as a moral agent. charged with the responsibility of self, which the rest of us are not empowered to assume. If a procedure is looked upon as a proper procedure and withholding it is likely to produce dangerous results, the physician should try to place all the facts before the person and if he or she is competent, respect his her decision.

63. Experimenting with human subjects is a very delicate area. Such experiments may be related to their disease or may be unrelated to their own disease. Questions of individual good and common (society's) good comes into play. So also, the problems of experimentation on children, foetus, prisoners and such others raise many ethical issues, Expeimental procedures of doubtful efficacy may be used, if no reliable remedy is available and the risks are not high. Experimentation for the good of others (non-therapeutic) may be done a) only with the enlightened consent of the subject; b) there is no danger of death or disabling injury; c) the clinical research conforms to the best scientific procedures; d) the subject is free to withdraw at any time from the project.

64. Transplantation

Organ transplantation has produced many ethical questions. Where it is renewable (bone marrow), there is little problem. So also procedures like corneal transplanatation is devoid of difficulties. But when it comes to the transplantation of kidney, heart or liver, many problems arise:

i. Cost: Organ transplantation is expensive. Could those resources be utilised better for the good of a larger number of people who are in urgent need of those resources?

ii. Commercialisation: Unfortunately, there is a lot of buying, selling and distributing of organs such as kidney. An investigation carried out showed that some of the slum dwellers in Bombay were made to part with their kidney for a small consideration.

There can also be buying priority in transplant procedure when the waiting list is long. Banning payments of any kind for human tissues or organs is a must.

Cadaveric organs can be used. Here again, problems come as regards the time of death. The organs and tissues must continue to be perfused with oxygenated blood. Circulation and respiration have to be continued. People have been depending on "brain death". This is not acceptable to many, including the Japanese.

65. Many ethical issues arise and each one will have to be decided at the particular time in the situation. There are many guidelines by different organisations like the World Medical Association's Draft Cod. of Ethics on Human Experimentation (therapeutic, non-therapeutic, children, etc). Where clear giudelines are not available, it may be useful to have a group of knowledgeable persons to decide on the appropriate action. The larger hospitals can have Ethics Committees. So also, there can be Ethics Committees at the Diocesan or Regional levels.

66. Responsible Parenthood

66.1. Rapid population growth is an important problem among the many faced by India; it is a multiplier and intensifier of other problems rather than the cause of them. It is necessary for each couple to consider and act towards responsible parenthood. Pope Paul VI said "The responsible exercise of parenthood implies that the husband and wife recognise fully their own duties towards themselves, towards the family and to-

wards society in a correct hierarchy of values. The essential ethical difference between Natural Family Planning and artificial contraception should be recognized in as much as the latter frustrates the natural process of human procreation. The tendency of many couples to turn to contraceptive practices should be tackled by a vigorous promotion of NFP. This is to be understood not merely as a technique to avoid conception but as a responsible means of respecting the procreative power of the specific act of conjugal love and thereby respecting the persons of the partners themselves.

66. 2. Responsible parenthood involves different responsibilities: those of the married couple to each other; to children who need love, and support; to the sacrament of marriage and to the society.

67. Confidentiality

The obligation of confidentiality or professional secrecy must be carefully fulfilled, not only as regards the information on the patient's charts and records, but also as regards confidential matters learned in the exercise of professional duties. Moreover, the charts and records must be duly safeguarded against inspection by those who have no right to see them.

68. Terminal Care

68.1. One area where Catholic health care personnel should devote greater attention is the care of terminally ill. A time comes when the professional treatment with drugs, surgery, radiotherapy and other procedures becomes of no avail in arresting the progress of the disease. Relief of the symptoms and support of the patient and family become most important. Terminal care gives added quality to the life remaining. One movement helping in this direction is the care being given in the hospices.

68.2. It is our duty to help the patient take a positive attitude to death as a bridge to Eternal life. St. Paul declares: "If our hope in Christ is good for this life and no more, then we deserve more pity than anyone else in the world" 1 Cor. 15-19. We must place our trust in Him and help the patient (and the near and dear ones) place his or her trust in Him. Most Indians, believe in life after death.

68.3. It is necessary to keep the patient in comfort till the moment of death. There are many small things that help to ease the pains of death. As a corollary, we must refrain from doing which prolong needlessly the agony. Un-necessary and expensive surgery, expensive life-support systems, costly medicines and other heroic measures

serve no useful purpose. We should take the view of the loved ones before we take the decision to refrain from further active therapy. Under such circumstances, we are not playing God as to who shall live and who shall die; we are only being obedient to and refraining from interfering with God's plan.

68.4. The most important relief that the patient needs in terminal care often is alleviation of pain and the fear of pain. Pain can be meaningful and can be offered as a sacrifice, ennrobling our life. Where pain is unbearable, it is necessary to give relief. We must recognise pain as the patient sees it and not as what we think it ought to be. To relieve pain, a doctor may have to take measures which may incidentally hasten death. If the doctor's aim is solely the relief of pain and not deliberately to shorten life, it is permissible. The doctor (or the nurse or anyone) may not, directly or indirectly, resort to any conduct with the intention of causing or hastening the patients' death. If a terminally ill patient expresses a desire to end his life, the health personnel may not facilitate the suicide; he or she must wean the patient away from the contemplated suicide, offering other help as feasible.

68.5. It is essential to provide all necessary facilities for the last rites to be performed, according to the faith and desire of the patient. Personnel of Catholic health facilities should make every effort to satisfy the spiritual needs and desires of non-catholics. The ministers of other Christian Communion and priests and leaders of other religions should be called in, if requested by the patient or relatives.

68.6. It would be good to be present at the moment of death. The doctor or the nurse should not try to disappear from the place at the time of bereavement. Their presence will be a solace and support to the family and loved ones.

X. Drug lists for 3 levels

(Recommended list of drugs and pharmaceuticals for the three levels of health care services)

PRIMARY

1	**Analgesics, Antipyretics, Nonsteroidal Anti-inflammatory Drugs :**	
	aspirin	Tablet 100 - 500 mg
	Paracetamol	tablet 100 - 500 mg
2	**Antidotes and other Substances Used in Poisonings :**	
	charcoal, activated	powder
3	**Anthelmintics**	
	mebendazole	tablet, 100 mg
4	**Antiamoebic Drugs**	
	chloroquine	tablet, 200 mg (as phosphate or sulphate)
5	**Antibacterial Drugs**	
	phenoxymethylpenicillin	tablet, 250 mg (as potassium salt) powder for oral suspension 250 mg (as potassium salt) 5 ml.
6	**Blood, Drugs affecting the**	
	ferrous salt	tablet, equivalent to 60 mg iron (as sulphate or fumarate) Oral solution., equivalent to 15 mg iron (as sulphate in 0.6 ml
	folic acid	tablet, 1 mg injection, 1 mg (as sodium salt) in 1 ml ampoule
7	**Dermatological Drugs**	
	benzoic acid + salicylic acid ointment or cream, 6% + 3%	
	gentian violet	solution
	calamine lotion	lotion
8	**Gastrointestinal Drugs**	
	antacid mixture	
	Mag. trisilicate	: 5 g
	Light mag. carbonate	: 5 g
	Sod. Bicarbonate	: 5 g

Peppermint water to make 100 *ml*
Dose : adult : 15 ml/*dose*

Aluminium hydroxide : tablet, 500 mg

9 Diarrhoea drugs used in

oral rehydration salts	g/litre
sodium chloride	3.5
sodium bicarbonate	2.5
potassium chloride	1.5
glucose	20.0

10 Local anaesthetic,
astringent and anti-inflammatory drug — ointment or suppository

11 Cathartics & laxatives
glycerine — suppository

12 Opthamological Preparations
Tetracycline — eye ointment, 1% (Hydrochloride)

13 Solutions correcting Water, Electrolyte and Acid-Base Disturbances
Oral rehydration salts (for glucose-salt solution) — (for composition see No 9 - Gastrointestinal Drugs - Oral rehydration salts)

14 Vitamins and Minerals

ascorbic acid	tablet, 50 mg
ergocalciferol	capusle or tablet, 1.25 mg (50000 IU) oral solution, 0.25 mg/ml (10000 IU)
retinol	capsule or tablet, 7.5 mg (25000 IU), 60 mg (200000 IU); oral solution, 15 mg (50000 IU)

SECONDARY LEVEL

1 Anaesthetics

oxygen	inhalation (medicinal gas)
lidocaine	injection, 1%, 2% (hydrochloride) in vial injection, 1%, 2% + epinephrine 1:100000 in vial

2	**Analgesics, Antipyretics, Nonsteroidal Anti inflammatory Drugs**	
	ibuprofen	tablet, 200 mg
	indomethacin	tablet, 25 mg
	pethidine	injection, 50 mg (hydrochloride) in 1 ml ampoule
3	**Antiallergics**	
	epinephrine	injection, 1mg (as hydrochloride) in 1 ml ampoule
4	**Antidotes and other Substances Used in Poisonings**	
	antisnake venom lyophilised polyvalent serum	
	atropine	injection, 1 mg (sulfate) in 1 ml ampoule
5	**Antiepileptics**	
	diazepam	injection 5 mg/ml in 2 ml ampoule
	phenobarbital	tablet, 50 mg, 100 mg syrup, 15 mg/5 ml
6	**Antiinfective Drugs**	
	piperaxine	tablet, 500 mg (citrate or adipate) elixir or syrup (as citrate) equivalent to 500 mg hydrate/5 ml
	metronidazole	tablet, 200 - 500 mg
	ampicillin	capsule or tablet, 250 mg, 500 mg (anhydrous) powder for oral suspension, 125 mg (anhydrous)/5 ml powder for injection, 500 mg (as sodium salt) in vial
	benzathine penicillin	injection, 1.44 g benzylpenicillin (=2.4 million IU) /5 ml in vial
	benzylpenicillin	powder for injection, 0.6 g (= 1 million IU), 3.0 g (= 5 million IU) (as sodium or potassium salt) in vial
	procaine benzylpenicillin	powder for injection, 1 g (= 1 million IU), 3 g (= 3 million IU)
	Chloramphenicol	capsule, 250 mg powder for injection, 1 g (as sodium succinate) in vial
	erythromycin	capsule or tablet, 250 mg (as stearate for ethylsuccinate) oral suspension

	125 mg (as stearate or ethylsuccinate) /5 ml powder for injection, 500 mg (as lactobionate) in vial
metronidazole	tablet, 200 - 500 mg injection, 500 mg in 100 ml
tetracycline (*adults only*)	capsule or tablet, 250 mg (hydrochloride)
dapsone	tablet, 50 mg, 100 mg
rifampicin	capsule or tablet, 150 mg, 300 mg
isoniazid	tablet, 100 - 300 mg
pyrazinamide	tablet, 500 mg
streptomycin	powder for injection, 1 g (as sulfate) in vial
thioacetazone + *isoniazid*	tablet, 50 mg + 100 mg + 300 mg
griseofulvin	tablet or capsule, 125 mg, 250 mg
sodium stibogluconate	injection, 33% equivalent to 10% antimony, in 30 vial
chloroquine	tablet, 150 mg (as phosphate or sulfate) syrup, 50 mg (as phosphate or sulfate)/5 ml
primaquine	tablet, 7.5 mg, 15 mg (as phosphate)
quinine	tablet, 300 mg (as bisulfate or sulfate) injection, 300 mg (as dihydrochloride)/in 2 ml ampoule
sulfadoxine + *pyrimethamine*	tablet, 500 mg + 25 mg
7 Antimigraine Drugs	
ergotamine	tablet, 2 mg (as tartrate)
8 Blood, Drugs affecting the	
Antianaemia drugs	
hydroxcobalamin	injection, 1 mg in 1 ml ampoule
9 Cardiovascular drugs	
glyceryl trinitrate	tablet 9 (súblingual) 0.5 mg
isosorbide dinitrate	tablet, (sublingual) 5 mg
lidocaine	injection, 20 mg (hydrochloride)/ ml in 5 ml ampoule
propranolol	tablet, 10 mg, 40 mg (hydrochloride) injection, 1 mg (hydrochloride) in 1 ml ampoule
Digoxin	tablet, 0.0625 mg, 0.25 mg oral solution, 0.05 mg/ml injection, 0.25 mg/ml in 2ml ampoule

10	**Anti-hypertensive drugs**	
	hydrocholorothiazide	tablet, 50 mg
	propranolol	tablet, 40 mg, 80 mg (hydrochloride)
11	**Drugs used in anaphylaxis**	
	epinephrine	injection, 1 mg (as hydrochloride) in 1 ml ampoule
12	**Dermatological Drugs**	
	miconazole	ointment or cream, 2% (nitrate)
	nystatin	ointment or cream, 100000 IU/g
	neomycin+bacitracin	ointment, 5 mg neomycin sulphate + 500 IU bacitracin zinc /g
	betamethasone	ointment or cream, 0.1% (as valerate)
	hydrocortisone	ointment or cream, 1% (acetate)
	lindane	cream or lotion, 1%
13	**Disinfectants**	
	chlorhexidine	solution, 5% (gluconate) for dilution
	iodine	solution, 2.5%
14	**Diuretics**	
	furosemide	tablet, 40 mg
		injection, 10 mg/ml in 2 ml ampoule
	hydrochlorothiazide	tablet, 50 mg
	mannitol	injectable solution, 10%, 20%
15	**Gastrointestinal Drugs**	
	cimetidine	tablet, 200 mg; 400 mg
		injection, 200 mg in 2 ml ampoule
	promethazine	tablet, 10 mg, 25 mg (hydrochloride)
		elixir or syrup, 5 mg (hydrochloride)
		5 ml injection, 25 mg (hydrochloride)
		ml in 2 ml ampoule
	atropine	tablet, 1 mg (sulfate)
		injection, 1 mg (sulfate) in 1 ml ampoule
	senna	tablet, 7.5 mg (sennosides)
16	**Hormones**	
	dexamethasone	tablet, 0.5 mg 4 mg
		injection, 4 mg (sodium, phosphate) in 1 ml ampoule
	hydrocortisone	powder for injection, 100 mg (as sodium succinate) in vial
	prednisolone	tablet, 5 mg

	compound insulin zinc suspension	injection, 40 IU/ml in 10 ml vial, 80 IU/ml in 10 ml vial
	insulin injection	injection, 40 IU/ml in 10 ml vial 80 IU/ml in 10 ml vial
17	**Anti- thyroid drugs**	
	potassium iodide	tablet, 60 mg
18	**Immunologicals**	
	anti-snake venom sera	injection
	tetanus antitoxin	injection, 50000 IU in vial
	BCG vaccine (dried)	injection
	diphtheria-pertussis-tetanus vaccine	injection
	diphtheria-tetanus vaccine	injection
	measles vaccine	injection
	poliomyelitis vaccine (live attenuated)	oral solution
	tetanus vaccine	injection
	rabies vaccine	injection
	typhoid vaccine	injection
19	**Muscle Relaxants (peripherally acting) and Cholinesterase inhibitors**	
	neostigimine	tablet, 15 mg (bromide) injection, 0.5 mg (metisulfate) in 1 ml ampoule
20	**Ophthalmological Preparations**	
	betamethasone	eye ointment, 1%
	hydrocortisone	eye ointment 1% (acetate)
	homatropine	solution (eye drops), 2% (hydrobromide)
21	**Oxytocics**	
	ergometrine	tablet, 0.2 mg (maleate) injection, 0.2 mg (maleate) in 1 ml ampoule
	oxytocin	injection, 10 IU in 1 ml ampoule
22	**Psychotherapeutic Drugs**	
	chlorpromazine	tablet, 100 mg (hydrochloride) syrup, 25 mg (hydrochloride) 5 ml injection, 25 mg (hydrochloride)/ml in 2 ml ampoule
	diazepam	tablet, 5 mg

23 Respiratory Tract, Drugs Acting on the

aminophylline	tablet, 200 mg injection, 25 mg/ml in 10 ml ampoule
salbutamol	tablet, 4 mg (sulfate) oral inhalation (aerosal) ,0.1 mg per dose, syrup, 2 mg (sulfate)/5 ml
codeine	tablet, 10 mg (phosphate)

24 Solutions Correcting Water, Electrolyte and Acid-base Disturbances

potassium chloride	oral solution
compound solution of sodium lactate	injectable solution
glucose	injectable solution, 5% isotonic, 50% hypertonic
glucose with sodium chloride	injectable solution, 4% glucose, 0.18% sodium chloride
	sodium chloride (Na+30 mlol/1CL 30 mmol/1)
sodium bicarbonate	injectable solution, 1.4% isotonic (na+167 mmol/1, HCO_3 167 mmol/1)
sodium chloride	injectable solution, 0.9% isotonic (Na+154 mmol/1, Cl- 154 mmol/1)
water for injection	in 2 ml, 5 ml, 10 ml ampoules

25 Vitamins and Minerals

nicotinamide	tablet, 50 mg
riboflavin	tablet, 5 mg
thiamine	tablet, 50 mg (hydrochloride)
calcium gluconate	injection, 100 mg/ml in 10 ml ampoule

TERTIARY

1 Anaesthetics

ether, anaesthetic	inhalation
halothane	inhalation
nitrous oxide	inhalation
thiopental	powder for injection, 0.5 g, 1.0 g (sodium salt) in ampoule
bupivacine injection	tropical forms, 2-4% (hydrochloride)

2 Analgesics, Antipyretics, Nonsteroidal Anti-inflammatory Drugs

pentazocine	tablet, 25 mg injection, 30 mg/ml
morphine	injection, 10 mg(sulfate or hydro-

	chloride) in 1 -ml ampoule
naloxone	injection, 0.4 mg (hydrochloride) in 1 ml ampoule

3 Antiallergics

chlorpheniramine	tablet, 4 mg (malete).
	injection, 10 mg in 1ml ampoule
cromoglicic acid	oral inhalation (cartridge)20 mg (sodium salt) per dose

4 Antidotes and other Substances Used in Poisonings

ipecacuanha	syrup, containing 0.14% ipecacuanha alkaloids calculated/as emetine
deferoxamine	injection, 500 mg (mesylate) in vial
dimercaprol	injection in oil, 50 mg/ml in 2 ml ampoule
naxlone	injection, 0.4 mg (hydrochloride) in 1 ml ampoule
protamine sulfate	injection 10 mg/ml in 5 ml ampoule
sodium calcium edetate	injection, 200 mg/ml in 5 ml ampoule
sodium nitrate	injection, 30 mg/ml in 10 ml ampoule
sodium thiosulfate	injection, 250 mg/ml in 50 ml ampoule

5 Antiepileptics

ethosuximide	tablet, 250 mg
phenytoin	tablet, 25mg, 100mg (sodium salt)/ml in 5 ml vial
carbamazepine	tablet, 200 mg
valproic acid	tablet, 200 mg (sodium salt)

6 Antinfective Drugs

pyrantel palmoate	chewable tablet, 250 mg oral suspension, 50 mg /ml
albendazole	tablet, 200 mg
diloxanide	tablet, 500 mg (furoate)
dehydroemetine	injection, 60 mg (hydrochloride) in 1 ml ampoule
cloxacillin	capsule, 500 mg (as sodium salt) powder for injection, 500 mg (as sodium salt) in vial
doxycline	capsule or tablet, 100 mg (as hydrochloride) injection, 100 mg (as hydrochloride/5 ml in ampoule)
gentamicin	injection, 10 mg, 40 mg (as sulfate)/ml in 2 ml vial
salazosulfapyridine	tablet, 500 mg

sulfadimidine	tablet, 500 mg oral suspension, 500 mg/5 ml injection, 1 g (sodium salt) in 3 ml ampoule
sulfamethoxazole + trimethoprim	tablet, 100mg + 20mg, 400mg + 80mg
clofazimine	capsule, 100mg
ethionamide	capsule or tablet, 150 mg, 300 mg tablet, 125 mg, 150 mg
ethambutol	tablet, 100-500 mg (hydrochloride)
diethylcarbamazine	tablet, 50 mg (citrate)
amphotericin B	powder for injection, 50 mg in vial
nystatin	tablet, 500000 IU
Ketoconazole	tablet, 200 mg
amodiaquine	suspension ,150 mg (as hydrochloride)/ 5 ml

7 Antineoplastic and Immunosuppressive Drugs

azathioprine	tablet, 50 mg powder for injection, 100 mg (as sodium salt) in vial
bleomycin	powder for injection, 15 mg (as sulfate) in vial
busulfan	tablet, 2 mg
Chlorambucil	tablet, 2 mg
Cyclophosphamide	tablet, 25 mg powder for injection, 500 mg, in vial
Cytarabine	powder for injection, 100 mg (as sodium salt) in vial
doxorubicin	powder for injection, 10 mg, 50 mg
flurouracil	injection, 50mg/ml in 5 ml ampoule
methotrexate	tablet, 2.5 mg (as sodium salt) in injection, 50 mg (as sodium salt)
procarbazine	capsule, 50 mg (as hydrochloride)
vincristine	(sulfate) in vial

8 Antiparkinsonism Drugs

biperiden	tablet, 2 mg (hydrochloride)
levodopa	tablet or capsule, 250 mg
levodopa + carbidopa	tablet, 100 mg + 10mg, 250mg+25mg

9 Blood, Drugs affecting

Antianaemic drugs

iron dextran	injection, equivalent to 50 mg iron/ml in 2 ml ampoule

Anticoagulants and antagonists

heprain	injection, 1000 IU/ml, 5000 IU/ml 20,000 IU/ml in 1 ml ampoule
phytonadione	injection, 10mg/ml in 5 ml ampoule
Warfarin	tablet, 5 mg (sodium salt)

10. Blood Products and Blood substitutes

dextran 70 and 40	injectable solution, 6%

11. Cardiovascular Drugs

propranolol	tablet, 10mg, 40mg (hydrochloride) injection, 1 mg (hydrochloride) in 1 ml ampoule
nifedipine	capsule, 10 mg
verapamil	tablet, 40 mg, 80 mg (hydrochloride) injection, 2.5 mg/ml (hydrochloride) in 2 ml ampoule
isoprenaline	tablet, 10mg; 15 mg (hydrochloride or sulfate)
procainamide	tablet, 250 mg, 500 mg, (hydrochloride) injection, 100 mg (hydrochloride)/ml in 10ml ampoule
quinidine	tablet, 200 mg (sulfate)
disopyramide	capsule, 100mg
hydralazine	tablet, 50 mg (hydrochloride)
sodium nitroprusside	powder for preparing infusion, 50g in ampoule
methyldopa	tablet, 250 mg
reserpine	tablet, 0.1 mg, 0.25 mg injection, 1 mg in 1 ml ampoule
digitoxin	tablet, 0.05 mg, 0.1 mg oral solution, 1mg/ml injection, 0.2 mg in 1 ml ampoule
dopamine	injection, 40 mg (hydrochloride)/ml in 5ml vial

12 Dermatological Drugs

aluminium acetate	solution, 13% for dilution
salicylic acid	solution, topical 5%

13 Diagnostic Agents

tuberculin purified protein derivative (PPD)	injection
fluorescein	eye drops, 1% (sodium salt)
adipiodone meglumine	injection, 25% in 20 ml vial
barium sulfate	powder
iopanoic acid	tablet, 500 mg

	meglumine amidotrizoate	injection, 60% in 20ml ampoule
	sodium amidotrizoate	injection, 50% in 20ml ampoule
14	**Diuretics**	
	spironolactone	tablet, 25 mg
	amiloride	tablet 5 mg (hydrochloride)
15	**Gastrointestinal Drugs**	
	magnesium hydroxide	oral suspension, equivalent to 550 mg magnesium oxide/10 ml
	metoclopramide	tablet, 10 mg (as hydrochloride)
16	**Hormones**	
	testosterone	injection, 200mg (enanthate) in 1 ml ampoule
		injection, 25 mg (propionate) in 1ml ampoule
	ethinylestradiol	tablet, 0.05 mg
	glibenclamide	tablet, 5 mg
	levethyrozine	tablet, 0.05 mg, 0.1 mg (sodium salt)
	propylthiouracil	tablet, 50 mg
17	**Immunologicals**	
	anti-D immunoglobulin (human)	injection, 0.25 mg/ml;
	antirabies hyperimmune	injection, 1000 IU in 5ml ampoule
	diptheria antitoxin	injection, 10,000 IU 20,000 IU, in vial
	immunoglobulin, human normal	injection
18	**Muscle Relaxants (peripherally acting) and Cholinesterase inhibitors**	
	gallamine	injection, 40mg (triethiodide)/ml in 2ml ampoule
	suxamethonium	injection, 50 mg (chloride)/ml in 2ml ampoule
19	**Ophthalmological preparations :**	
	Silver nitrate	Solution (eye drops), 1%
	Sulfacetamide	eye ointment, 10% (sodium salt)
		solution (eye drops), 10% (sodium salt)
	tetracaine	solution (eye drops), 0.5% (hydrochloride)
	pilocarpine	solution (eye drops) 2%, 4% (hydrochloride or nitrate)

	acetazolamide	tablet, 250 mg
20	**Peritoneal Dialysis solution :**	
	intraperitoneal dialysis solution (of appropriate composition)	parenteral solution
21	**Psychotherapeutic Drugs :**	
	amitriptyline	tablet, 25mg (hydrochloride)
	fluphenazine	injection, 25mg (decanoate or enanthate) 1 ml ampoule
	haloperidol	tablet, 2 mg injection, 5 mg in 1 ml ampoule
	lithium carbonate	capsule or tablet, 300mg
22	**Respiratory Tract, Drugs Acting on the**	
	beclomethasone	oral inhalation (aerosol), 0.05 mg. (diproprionate) per dose
	cromoglicic acid	oral inhalation (cartridge), 20 mg (sodium salt) per dose
	Ephedrine	tablet, 30mg (as hydrochloride) elixir, 15mg (as hydrochloride)/ 5ml, injection, 50mg (sulfate) in 1ml ampoule
	Solutions correcting water, Electrolyte and Acid-base disturbance	
	Potassium chloride	injectable solution
23	**Vitamins and Minerals :**	
	ergocalciferol	capsule or tablet, 1.25 mg (50.000IU) oral solution, 0.25 mg/ml (10,000 IU)
	pyridoxine	tablet, 25mg (hydrochloride)

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